Division	Division of Health Service Regulation									
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED					
		HAL011285	B. WING		06/0	R 01/2016				
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS. CITY. S	STATE, ZIP CODE						
			NSON COVE	,						
CANDLE	R LIVING CENTER	CANDLER	R, NC 28715							
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE				
{C 000}	{C 000} Initial Comments		{C 000}							
	Report of Follow-up 6-1-2016.	Survey by Dennis Harrell on								
	Several deficiencies were not corrected. Further action is required.									
{C 166}	Housekeeping-Maintained Free of Hazards		{C 166}							
	orderly manner, free hazards;	06 HOUSEKEEPING AND								
	ceilings in the launce evidently caused by	on, parts of the walls and dry were covered in black mold a leaking roof. Persistent dous to the health of the								
{C 189}	Building Equipment	: Maintained Safe, Operating	{C 189}							
	mechanical, and plu care home shall be operating condition (k) This Rule shall facilities with the ex	11 OTHER and all fire safety, electrical, umbing equipment in an adult maintained in a safe and								

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01		(X3) DATE SURVEY COMPLETED							
		HAL011285	B. WING		06/0	? 1/2016						
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE											
CANDLER LIVING CENTER 136 ROBINSON COVE ROAD CANDLER, NC 28715												
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE						
{C 189}	This Rule is not me 2. Based on observation for rated walls and/ in locations. Holes sealed with materia one-hour fire rated possibility that a fire quickly spread to ot Findings include: a. Hole about 3 fee ceiling, b. Parts of laundry water damage,		{C 189}									

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